No. 2
-13-40
17-39
X2315

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

36317 a

State File No.

NOV 25 1940

Registration District No. 784

Primary Registration District No. 21D

Registrar's No. 1928

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Jennings Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Elms Nursing Home (If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community since 1931

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis Cy
(c) City or town Overland, Mo (If outside city or town limits, write "RURAL")
0
(d) Street No. 2930 Edgar (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CREGGER, Walter
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex male
5. Color or race wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Myrtle Cregger
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 4-13-1876 (Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Hawk Point, Lincoln Cy Mo (City, town, or county) (State or foreign country) 0
10. Usual occupation NONE 4
11. Industry or business
MOTHER FATHER
12. Name DON'T KNOW
13. Birthplace DON'T KNOW (City, town, or county) (State or foreign country)
14. Maiden name DON'T KNOW
15. Birthplace DON'T KNOW (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Mae Davis
(b) Address 2930 Edgar, Overland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 17 40 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Clea Cemetery
18. (a) Signature of funeral director Ostegaard Funeral Home
(b) Address 9222 Lackland, Overland Mo.
19. (a) OCT 12 1940 (Date received local registrar) (Registrar's signature) 20

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1940 hour 12 minute 25 A.M.
21. I hereby certify that I attended the deceased from September 13th 40 to October 10 1940 that I last saw him alive on October 10th 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: multiple metastases, carcinoma	8 mo
Due to: carcinoma of lip and cervical glands	1 yr
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. Johnston (M. D. or other) 1
Address St. Louis Co. Hosp. Date signed 10-12-40

(Licensed Embalmer's Statement on Reverse Side)

45W

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed A. C. Ortmann

Licensed Embalmer No. 3478

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36317

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 1928-

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jennings Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____
(If outside city or town limits write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Walter Gregger
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife ____ 6. (c) Age of husband, or wife, if alive ____ years

7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day: hr. ____ min.

9. Birthplace ____ (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) 10-12-40 (Date received local registrar) (b) T. Remey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11 - 40
year ____ hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Multiple met. Car -	8 mo
Due to: Carcinoma of lip and cervical glands + Mel. Ca. primary	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations 53	
Of autopsy ____	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature R Johnston M.D. (M. D. or other)
Address C. Hosp. Date signed ____

SUPPLEMENTARY